STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 13, 14, 15 & 16, 2012 Facility number: 000131 Provider number: 155226 AIM number: 100274910 Survey team: Diana Zgonc, RN, TC Connie Landman, RN Lori Brettnacher, RN Christi Davidson, RN Census bed type: SNF: 16 SNF/NF: 97 Total: 113 Census payor type: Medicare: 18 Medicaid: 86 Other: 9 Total: 113 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 Quality review completed on August 21, 2012 by Bev Faulkner, RN	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after September 7, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure resident safety as evidenced by an unlocked medication cart left unattended and pills disposed of in a visible, accessible trash can connected to the medication cart. This involved 1 of 1 medication carts on the Memory Care Unit with the potential to affect 3 of 3 randomly observed residents (#89, #103, #144) Findings include: 1. During a medication observation on 8/16/12 at 8:13 a.m., Licensed Practical Nurse [LPN] #2 was located at the medication cart with a medicine cup of pills. LPN #2 did not lock the medication cart. LPN #2 left the medication cart unattended to administer medications. Upon her return to the medication cart, LPN #2 indicated, "I'll be right back, I have to unlock a closet." The medication cart remained unlocked and unattended. Resident #144 walked from the dining	F0323	**F 323** It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Medication carts are now locked when unattended, and medications not used are now destroyed per policy. The nurse was removed from the floor and provided with immediate in servicing. The video was reviewed to further gain insight of the events that occurred. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents of the Memory Care	09/07/2012

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	area in the Memory Care Unit past the medication cart in the hall way. Resident #144 leaned on the medication cart for balance, then continued walking down the hall. The Record for Resident #144 was reviewed on 8/16/12 at 10:20 a.m. Diagnoses included but were not limited to dementia with behaviors and altered mental status. The most recent quarterly Minimum Data Set [MDS] Assessment, dated 6/12/12, indicated Resident #144 scored 4 out of a possible 15 on the Brief Interview for Mental Status [BIMS], indicating severe cognitive impairment. 2. During a medication observation on 8/16/12 at 8:20 a.m., LPN #2 disposed of a medicine cup with 6 pills [Calcium 600 milligrams [mg] with vitamin D 400 IU one tablet, carbidopa/levo 25-100mg one tablet(to treat Parkinson's disease), Namenda 10mg one tablet (to treat Alzheimer's disease), folic acid 1 mg one tablet, and two tablets of acetaminophen 325mg] mixed in oatmeal in the open trash can connected to the base of the medication cart. Resident #89 and		Unit have the potential to be affected. At the time of the incident, all med carts were examined to ensure their operability, and that they were kept in accordance with policy and regulations. All nurses were provided with inservicing regarding storage and disposal of medication by the Staff Development Coordinator on 08/16/12. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** In order to correct the practice, the facility developed a new systemic protocol. Nurse managers will inspect the medication/treatment carts, at varied times, to ensure they are locked; no less than four times per shift. In addition, the policy and procedure pertaining to destruction will be posted on all medication carts. Nurse managers will monitor the units at varied times, no less than four times per shift, to ensure proper disposal of medication. If non-compliance is found, nurses will be subjected to immediate education and disciplinary action up to/and including termination. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**	

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	Resident #103 were ambulatory in the vicinity of the medication cart. The record for Resident #89 was reviewed on 8/16/12 at 10:14 a.m. Diagnoses included but were not limited to Alzheimer's dementia and hypertension. The most recent quarterly MDS Assessment, dated 7/24/12, indicated Resident #89 was a 0 out of a possible 15 on the BIMS. The record for Resident #103 was reviewed on 8/16/12 at 10:16 a.m. Diagnoses included but were not limited to alcohol type dementia and alcohol induced anxiety. The most recent admission MDS Assessment, dated 5/31/12, indicated Resident #103 scored 11 out of a possible 15 on the BIMS, indicating moderate cognitive impairment.. During an interview on 8/16/12 at 8:30 a.m., RN #1 was asked the policy on disposing of medications, and she indicated, "supposed to flush with another nurse." A facility policy provided by the		A Medication Administration Pass CQI tool will be completed by the DNS or designee weekly X4, monthly X3, and quarterly, thereafter for at least 6 months to ensure compliance has been achieved.	

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	Director of Nursing on 8/16/12 at 10:54 a.m., indicated, "...During the medication administration process the unlocked side of the cart must always be in full view of the nurse...." 3.1-45(a)(1)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to follow the physician orders for monitoring the blood levels of Depakote (Valproic Acid) for effectiveness for 1 of 10 residents reviewed for unnecessary medications. (#15) Findings include: The record for Resident #15 was reviewed on 8/15/12 at 10:03 a.m.	F0329	**F 329** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** It is the practice of this provider to ensure that each resident's drug regimen remains free from unnecessary drugs, without adequate monitoring. The physician was contacted and notified of missed labs and new	09/07/2012

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	Diagnoses included but were not limited to diabetes, dementia with agitation, anemia, hypertension, insomnia and depression. A physician's order, dated 5/17/12, indicated, "...Depakote level monthly...." A current recapitulation, dated for 8/1/12 through 8/31/12, with a physician's order ,dated 6/6/12, indicated, "...Divalproex sprinkle 125mg cap take 4 capsules (500mg) twice daily (For: Depakote...." A laboratory report indicated the drug level for the specimen collected on 4/24/12 for Valproic Acid [Depakote] was 55 with a normal range of 50-100. During an interview on 8/15/12 at 10:43 a.m., RN #1 was requested to provide laboratory results for the Depakote drug level for May, June and July 2012 for Resident #15. During an interview on 8/15/12 at 11:04 a.m., RN #1 indicated no results were found for a Depakote drug level for Resident #15 for May, June and July 2012. RN #1 indicated she would request assistance from the Director of Nursing [DoN] in		orders were obtained in regards to the frequency of monitoring. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** Residents receiving medications requiring blood levels be drawn, have the potential to be affected. All charts will be audited for medications that require blood levels be performed. Physicians will be contacted with a current list of medications requiring monitoring and the frequency of monitoring to verify their current orders. All orders will be updated with laboratory services to ensure adequate monitoring. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur:** An inservice was provided regarding the lab-tracking process by the Staff Development Coordination on 08/16/12, 08/29/12, and 08/30/12. Lab tracking books will be updated with any new lab orders during daily clinical meeting and upon a resident's intra-facility transfer to a new unit.	

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	locating the laboratory results. During an interview on 8/15/12 at 12:29 p.m., the DoN indicated she had a call into the lab to "see what happened." During an interview on 8/15/12 at 3:56 p.m., RN #1 indicated the blood draw to obtain a Depakote drug level was not done in May, June or July 2012 for Resident #15. During an interview on 8/16/12 at 10:55 a.m., the DoN indicated the blood draw to obtain a Depakote drug level was not done in May, June or July 2012 for Resident #15. The DoN indicated the Depakote was not used to control seizures. 3.1-35(g)(2)		**1. Facility draw list will be compared and/or reconciled three times per day with the lab draw list.** **2. Nursing staff will update draw list with each new lab order.** **3. When lab results are received, physician will be notified in accordance with policy.** **4. Unit manager is to oversee the lab draw process** **5. The DNS will monitor to ensure labs are drawn per physician orders** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place** An Unnecessary Medication CQI tool will be completed by the DNS or designee weekly X4, monthly X3, and quarterly, thereafter for at least six months, to ensure compliance has been achieved.	